STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155586	A. BUILDING 00 B. WING	01/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN LIFE VILLAGES	6701 S ANTHONY BLVD FORT WAYNE, IN 46816

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for a Recertification and State Licensure Survey. Survey dates: January 23, 24, .25, 26, & 27, 2012 Facility number: 000283 Provider number: 155586 AIM number: 100275020 Survey team: Sue Brooker RD TC Rick Blain RN Diane Nilson RN Angie Strass RN Ann Armey RN (January 23 & 24, 2012) Ellen Ruppel RN (January 23 & 24, 2012) Census bed type: SNF/NF: 128 Residential: 45 Total: 173 Census payor type: Medicare: 16 Medicaid: 94 Other: 63 Total: 173 Stage 2 sample: 38	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Residential sample: 8 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed 1/31/12 Cathy Emswiller RN			

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F0323 SS=G	The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.			
	Based on record review and interview, the facility failed to ensure 1 resident (#149) of 6 residents who met the criteria for accidents was free of an accident which resulted in a fracture. Finding Includes: On 1/26/12 at 9:30 a.m. review of the closed clinical record for resident #149 indicated he was admitted to the facility on 8/11/11 and died on 12/29/11. The resident was admitted with diagnoses including but not limited to Dementia, cardiovascular disease, hypertension, and personal history of falls. Review of the residents plan of care dated 9/10/11 indicated the resident was at risk for falls due to decreased mobility and history of falls. Review of the resident's incidents of falls on 1/26/12 at 10:00 a.m. indicated the resident had fallen on 10/5/11 at 2:30 p.m. and the facility had implemented monitoring the residents whereabouts and assisting with transfers. On 10/5/ 11 at 3:30 p.m. the resident fell again and the	F0323	**What measures were taken for residents directly affected?** Resident #149 was sent to the hospital for evaluation and treatment. **What measures were put in place to identify other residents at risk?** All residents were noted to be at risk from this practice. All residents residing in the facility have had a new Fall Assessment completed. An audit was performed to ensure those residents with Fall Assessment scores identifying them as high risk had appropriate interventions in place. **What systemic change was put in place to ensure the deficient practice does not recur?** The policy and procedure for "Fall Review/Falling Star Program" was reviewed and revised. Nursing staff were in-serviced on the revised/updated policy and procedure. Staff has been in-serviced to understand that all interventions on the care plan must be applied as prescribed until otherwise changed or discontinued by the physician and/or interdisciplinary team. Fall process reviewed:· Added Fall Quality Assurance protocol to the process to be initiated by nurse manager/house supervisor within 24 hours of the fall incident.·	02/26/2012

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	facility implemented an alarming seat belt. Review of the clinical record indicated the resident had been in physical and occupation therapy since 9/30/11. On 10/9/11 at 11:05 a.m. the resident fell and fractured his hip. Review of the "Incident Investigation Worksheet" dated 10/9/11 indicated the resident was trying to ambulate without help. Review of the "Fall Committee Review", which was not dated, indicated the resident had been in a recliner without a seatbelt on, which was the previous intervention. Interview with the Director of Nursing on 1/27/12 at 11:12 a.m. indicated when the resident fell and fractured his hip he had been seated in a recliner with his feet up. She further Indicated the nurse had been seated next to him, and got up to answer the phone. On 1/26/12 at 10:30 a.m. review of the "summary of the incident" indicated the resident was seated in a recliner in the lounge. The nursing supervisor had just taken a phone call from the residents daughter. The daughter had inquired if she could come and take the resident out of the facility around 1:00 p.m. The nursing		Added Fall Review Followup to be done during the neighborhood meeting approximately 72 hours after initial Fall Committee Review.· Review weekly during Resident Review, identifying any potential trends. **How will the corrective action be monitored?** The Director of Nursing or designee will audit all occurrences on a weekly basis for 8 weeks and on a monthly basis for 12 weeks. A monthly report of audit results will be submitted to the Quality Assurance Committee for the duration of the audits noted above. Should the committee feel that systemic compliance is not being achieved then audits will continue, with possible additional corrective action, until compliance has been achieved.	

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	supervisor went to ask the resident if he would like to go out with his daughter later in the afternoon and he replied it was okay. The nursing supervisor went back to the phone to give the response and heard a loud thud. Upon returning, found the resident lying on his left side on the floor of the lounge. 3.1-45(a)(2)			

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F0431 SS=E	The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview, and record review, the facility failed to ensure the temperature of 3 medication refrigerators was maintained between 36 and 46 degrees Fahrenheit [F] in a sample of 7 medication refrigerators	F0431	**What measures were taken for residents directly affected?** Residents #105, #66, #87, #46, #17, #9, #79, #139, #64, #84, #29, and #31 had no negative outcomes exhibited as a result of this practice. **What measures were put in place to identify**	02/26/2012

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	observed. This had the potential to affect 12 of 12 residents with medications stored in the refrigerators (Residents #105, #66, #87, #46, #17, #9, #79, #139, #64, #84, #29, and #31.) Findings Include: 1. During tour of the facility medication storage areas on 1/25/12, beginning at 1:25 p.m., the following was observed: The thermometer in the refrigerator in the medication room on C wing (Lilac West) was observed, with LPN #2 in attendance. The thermometer indicated the temperature was 20 degrees F. LPN #2 indicated the temperature dial in the refrigerator was too cold, and was observed to turn the temperature dial down. The Director of Nursing Services was observed to put a brand new thermometer in the refrigerator, at 1:40 p.m. on 1/25/12, and at this time the original thermometer was again checked and read 40 degrees F. A temperature log for January, 2012, reflecting temperatures taken in the medication refrigerator, indicated the temperatures, taken on the night shift,		**other residents at risk?** While this had the potential to affect residents, it was noted per statement from the consultant pharmacist that as long as the medications were not frozen, there would be no adverse affects on the medication and they would be "okay to use". The refrigerators in all medication rooms were audited. New refrigerator temperature log sheets specifically identifying the appropriate temperature range were placed on each medication room refrigerator. **What systemic change was put in place to ensure the deficient practice does not recur?** The policy and procedure for "Storage and Expiration Dating of Medications, Biologicals, Syringes, and Needles" was reviewed and did not require revision. Nursing staff that routinely administer medications were in-serviced on the policy and procedure, particularly items related to storage of medication and appropriate refrigeration temperatures. The night shift nurse and/or QMA on duty is responsible for ensuring that medication room refrigerator temperatures are checked and recorded nightly, making any adjustments/notifications regarding consistent variation from appropriate temperature readings. **How will the corrective action be monitored?** The Director of	

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	for the month of January, between January 3 and January 25, with the exception of 1 day when the temperature was not recorded, ranged between 20 degrees to 26 degrees F. The most recent temperature was recorded as 20 degrees F., taken at 12:15 a.m., on 1/25/12. A printed note, at the bottom of the temperature log indicated, "Acceptable temperature ranges for refrigerators are 41 F and below -10 F to 0-F for freezers." The following medications were observed to be in the medication refrigerator on the C Wing at 1:45 p.m., on 1/25/12: Resident #105: 6 unopened vials of Novolin 70/30 Insulin (an injectable medication used to treat diabetics); the vials felt very cold, but were not frozen; Resident #66: 3 unopened vials of Humalog Insulin, and 1 unopened vial of Lantus Insulin; Resident #87: 1 unopened vial of Lantus Insulin; Resident #46: 1 unopened vial of		Nursing or designee will audit all medication storage on a weekly basis for 8 weeks and on a monthly basis for 12 weeks. A monthly report of audit results will be submitted to the Quality Assurance Committee for the duration of the audits noted above. Should the committee feel that systemic compliance is not being achieved then audits will continue, with possible additional corrective action, until compliance has been achieved.	

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	Lantus Insulin; Resident #17: 1 unopened vial of Novolog Insulin; Resident #9: 1 full box of Tucks suppositories; Resident #79: 1 box of Tucks suppositories containing 18 suppositories. Also stored in the refrigerator were 3 vials of unopened Aplisol (solution used for tuberculin skin testing) for facility use, and 1 vial of pneumovax (vaccine) for facility supply. Temperatures in the medication refrigerator on A Wing (Gardenia Grove East), were checked at 2:14 p.m., on 1/25/12, with RN #3. The thermometer in the refrigerator indicated 34 degrees F. A temperature log for December, 2011, and January, 2012, indicated temperatures were taken 11 days in December and ranged between 23 degrees F. and 0 degrees Celsius (0 degrees Celsius equals 32 degrees F. The January, 2012 temperatures ranged between 30 degrees F. and 38 degrees F. The most recent temperature taken indicated 30			

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	degrees F., taken at 7:00 a.m., on 1/25/12. These temperatures were recorded on the same type of log as the temperatures on C Wing. The following medications were observed to be in the medication refrigerator on A Wing; Resident #139: A multidose vial of Forteo 600 micrograms/2.4 milliliter injectable (for osteoporosis); Resident # 64: An unopened vial of Novolog Insulin, and an unopened vial of Lantus insulin; Resident #84: An unopened vial of Novolog Insulin; Resident #29: 2 opened multidose allergy shot vials, 1 of the vials labeled for molds and mites, and the other for pollen. Temperatures in the refrigerators on the 2nd floor, rehab unit, were observed at on 1/25/12, with QMA #4. The thermometer in the refrigerator indicated a temperature of 28 degrees F. Review of the temperature logs for			

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	January, 2012 indicated daily temperatures were recorded and ranged between 25 degrees F. and 36 degrees F, with 11 of the readings recorded in the 25 to 29 degree range. The following medications were observed to be in the refrigerator on the rehab unit: Resident #31: 10 wrapped Dulcolax suppositories; An opened vial of Aplisol, and 3 vials of Pneumovax. The Director of Nursing Services (DNS) was interviewed at 3:28 p.m. on 1/25/12. The DNS indicated she thought staff ran out of the temperature logs for the refrigerators in the medication rooms, so must have used temperature logs from the dietary department to record the temperatures in the medication rooms. She indicated the dietary logs for recording temperatures and the logs used to record refrigerator temperatures in the medication rooms were different. The Assistant DNS was Interviewed at 3:51 p.m. on 1/25/12. She indicated she had just talked to the			

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	pharmacist who indicated the lower temperature in the medication refrigerators would not have any adverse effects on the medications stored in the refrigerators as long as the medications were not frozen. The pharmacy consultant was interviewed at 9:45 a.m. on 1/26/12, in the facility. She indicated as long as the medications were not frozen, there would be no adverse affects on the medication, and they would be ok to use. The DNS was Interviewed on 1/26/12 at 11:10 a.m., and indicated she did not know if the nurses were ever in-serviced on acceptable refrigerator temperatures for the medication room refrigerators, but they were using the wrong temperature log sheets to record refrigerator temperatures in the medication rooms. She indicated they were using the temperature logs for dietary temperatures, so they thought these were acceptable temperatures for the medication storage. Review of the policy for storage and expiration dating of medications, dated May of 2010, and provided by the DNS on 1/25/12, indicated the facility should ensure that			

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	medications and biologicals were stored at their appropriate temperatures according to the United States Pharmacopeia guidelines for temperature ranges. The temperature for refrigeration indicated 36 to 46 degrees F. 3.1-25(m)			

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F0514 SS=D	The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.			
	Based on interview and record review, the facility failed to document the treatment ordered for a new pressure ulcer for 1 resident (Resident #23) of 3 residents who met the criteria for pressure ulcers in the sample of 38. Findings include: Review of the clinical record for Resident #23 on 1/24/12 at 8:20 a.m., indicated the following: diagnoses included, but were not limited to, peripheral vascular disease, osteoporosis, and kyphosis. LPN #1 was interviewed on 1/23/12 at 11:36 a.m. During the interview she indicated Resident #23 had a pressure ulcer on her buttocks. A Braden Scale for Predicting Pressure Sore Risk for Resident #23, dated 11/12/11, indicated a total	F0514	**What measures were taken for residents directly affected?** The medical record for resident #23 has been reviewed and a current treatment/plan of care is in place for the identified condition. **What measures were put in place to identify other residents at risk?** All residents with pressure areas were reviewed and treatment orders were noted to be in place. **What systemic change was put in place to ensure the deficient practice does not recur?** · The policy and procedure for "Physician Medication/Treatment Orders" was reviewed and revised. · The policy and procedure for "Management of Skin and Prevention of Pressure Ulcers" was reviewed with no revisions needed. · Nursing staff were in-serviced on the related/updated policies and procedures. · Skin condition reporting process reviewed:o Added Skin Quality Assurance protocol to the process initiated by nurse manager/house	02/26/2012

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	score of 15 which placed her at low risk for pressure ulcers. A physician's order for Resident #23, dated 11/2/11, indicated Rx Compound as needed. The physician's order also indicated to apply as needed to left thigh and calf. A Skin & Wound Conditions report for Resident #23, dated 12/13/11, indicated a Stage 2 ulcer, measuring 0.6 cm (centimeters) x 0.7 cm, was observed on her right lower buttocks. The report also indicated no odor or drainage was present, but her skin surface was open and raw. The report further indicated the Nurse Practitioner (NP) was notified. A Progress Notes for Resident #23, dated 12/13/11, indicated she had recently been evaluated and admitted to Hospice. The progress note also indicated '...Res (resident) also has a new pressure area to her right upper thigh stage 2, rx (prescription) compound applied...." The EMAR (Electronic Medication Administration Record) for December 13, 2011 through December 27, 2011, indicated Rx Compound as needed. Apply as needed to left thigh and calf. The EMAR did not indicate		supervisor within 24 hours of the occurrence.o Added Skin Review Followup to be done during the neighborhood meeting approximately 72 hours after initial Skin Committee Review.o Review weekly during Resident Review, identifying any potential trends. · All medical charts will be checked by the night shift nurse to validate that all physician orders have been processed. If the night shift nurse finds an order that has not been processed, she/he will process the order.o The night shift supervisor will run a nightly report identifying all new physician orders for the last 24 hours. These orders will be double checked by night shift licensed staff with appropriate followup as indicated. **How will the corrective action be monitored?** The Director of Nursing or designee will audit all occurrences on a weekly basis for 8 weeks and on a monthly basis for 12 weeks. A monthly report of audit results will be submitted to the Quality Assurance Committee for the duration of the audits noted above. Should the committee feel that systemic compliance is not being achieved then audits will continue, with possible additional corrective action, until compliance has been achieved.	

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	the Rx Compound had been applied to the new pressure ulcer on her buttocks. A Consultant Report from the Nurse Practitioner for Resident #23, dated 12/28/11, indicated she was requested to see resident due to a change in the appearance of the pressure ulcer on her right lower buttocks. The report also recommended xeroform and adhesive border foam. A physician's order for Resident #23, dated 12/28/11, indicated xeroform with bordered foam adhesive to open area buttock BID. A Skin & Wound Conditions report for Resident #23, dated 12/28/11, indicated the pressure ulcer on her right lower buttocks was assessed by the Nurse Practitioner on this date. A new order was received for xeroform covered with bordered foam adhesive to area on buttocks BID (twice a day). The Administrator was interviewed on 1/26/12 at 9:55 a.m. During the interview he indicated Resident #23 had an order for Rx Compound which was already being used for treatment to her light thigh and calf. He also indicated the NP had seen Resident			

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	155586	A. BUILDING 00 B. WING	01/27/2012

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	#23 on 12/13/11 and had verbally instructed the staff to use the Rx Compound on the new open area on her right lower buttock. The NP was interviewed on 1/26/11 at 12:24 p.m. During the interview she indicated LPN #1 had contacted her regarding the new pressure ulcer. She also indicated she understood the facility already had an order for the Rx Compound and informed LPN #1 to continue using the Rx Compound on the new pressure ulcer. She further indicated days later LPN #1 contacted her again concerning the condition of the pressure ulcer. At that time the NP examined the pressure ulcer, wrote a progress note, and ordered a change in treatment. LPN #1 was interviewed on 1/26/12 at 3:25 p.m. During the interview she indicated she had applied the Rx Compound to the new pressure area on Resident #23 as recommended by the NP. She also indicated she failed to record the new order and document the treatment for the new pressure ulcer. A current facility policy "Processing Physician Orders", revised on 5/26/08 and provided by the Director of			

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	Nursing on 1/27/12 at 11:10 a.m., indicated "...Medications will be administered in a safe, error free manner only upon the clear, complete, and signed order of a person lawfully authorized to prescribe medications...All orders from a licensed practitioner for resident medications and treatments shall be processed through the nurses' station by a licensed nurse and entered in the residents' medical record and Optimus...Transcribe newly prescribed medications onto the medication and treatment records (MAR/TAR)...." 3.1-50(a)(1)			

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R0091	(h) The facility shall establish and implement a written policy manual to ensure that resident care and facility objectives are attained, to include the following: (1) The range of services offered. (2) Residents' rights. (3) Personnel administration. (4) Facility operations. The policies shall be made available to residents upon request.			
	1. Based on observation, interviews and record review, the facility failed to establish a policy related to monitoring the accuracy of 2 of 2 blood monitoring devices used for 7 of 8 diabetic residents, whose blood sugars were being checked by staff members. Residents #8, #9, #33, #38, #43, #44, and #46. 2. Based on record review and interviews, the facility failed to follow the policy for neurological checks for 1 resident in a sample of 7, who sustained a fall with head injury and hematoma. Resident #12 Findings include: 1. During the observation of the medication cart, on 1/24/12 at 9:30 a.m., with RN #400, the blood glucose monitoring devices (Assure Platinum Blood Glucose System) were observed in each of the two medication carts on the assisted living unit used for 7 of 8 diabetic residents, whose blood sugars	R0091	**Part One What measures were taken for residents directly affected?** No residents were directly affected by this noncompliance. **What measures were put in place to identify other residents at risk?** All residents are at risk from this noncompliance. No residents have exhibited any negative outcomes as a result of this practice. **What systemic change was put in place to ensure the deficient practice does not recur?** The protocol regarding "Glucometer Use" was reviewed and revised as deemed appropriate. Nursing staff that routinely perform blood glucose checks were in-serviced on the protocol, particularly items related to calibrating and testing glucometers. **How will the corrective action be monitored?** The Director of Nursing or designee will audit all glucometer calibration/testing records on a daily basis for 8 weeks and on a weekly basis for 12 weeks. A monthly report of audit results will be submitted to the Quality	02/26/2012

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	were being checked by staff members. Residents #8, #9, #33, #38, #43, #44, and #46. The Quality Control Record in each cart was reviewed, with RN #400, and no entries had been made since 11/20/11. When queried about a system for monitoring the device, RN #400 indicated the facility did not have a policy regarding how often or when the system should be monitored. She indicated the facility had been using the Assure devices for "over a year." Review of the information from the manufacturer, which was found in the monitoring solution box, the instructions were as follows: "USE CONTROL SOLUTION: * Before testing with the system for the first time. * When you open a new bottle of test strips. * Whenever you suspect the meter or test strips may not be functioning properly. * If test results appear to be abnormally high or low or are not consistent with clinical symptoms. * The test strip bottle has been left open or has been exposed to light, temperatures below 39 (degrees) F (Fahrenheit) (4 C) (Celsius), or above 86 F (30 C), or		Assurance Committee for the duration of the audits noted above. Should the committee feel that systemic compliance is not being achieved then audits will continue, with possible additional corrective action, until compliance has been achieved. **Part Two 1. What measures were taken for residents directly affected?** Resident #12 did experience a fall. No negative outcomes were observed as a result of the related noncompliant practice. **What measures were put in place to identify other residents at risk?** All residents that experience a fall are at risk from this noncompliant practice. All residents that experienced a fall during the time period specified were reviewed for similar circumstances without additional findings. **What systemic change was put in place to ensure the deficient practice does not recur?** The protocol regarding “Assisted Living Services and Amenities” was reviewed and revised as deemed appropriate. Nursing staff/managers routinely working in Residential/Assisted Living were in-serviced on the protocol. The charge nurse is responsible for initiating and completing an incident report with Fall Committee Review protocol for any resident that experiences a fall. If a resident’s fall is unwitnessed, a Neuro Checklist will be initiated per standard	

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	humidity levels above 80%. * To check your technique. * When the meter has been dropped or stored below 32 F (0 C) or above 122 F (50 C). * Each time the batteries are changed." There was no record of when the new test strips had been obtained, when the batteries had been changed or if any of the other indications had been followed. 2. The clinical record of Resident #12 was reviewed, on 1/23/12 at 10:20 a.m., and indicated the resident had lived in the facility since 2004. His diagnoses included, but were not limited to: congestive heart failure, prostatitis and history of transient ischemia attacks. Nurses notes, dated 7/28/11 at 9:15 p.m., indicated the resident had sustained a fall and hit his head. The note indicated he had a "golf ball sized" hematoma on the right occipital area and a skin tear on the mid back. His vital signs were recorded as: blood pressure 142/63, pulse 92, respirations 20 and temperature 97. The note indicated a neurological check at the time was negative. The next nurses note, at 10:15 p.m., indicated he had refused to go to the hospital for evaluation.		protocol noted on the form. **How will the corrective action be monitored?** The Director of Nursing or designee will audit all resident fall documentation on a weekly basis for 8 weeks and on a monthly basis for 12 weeks. A monthly report of audit results will be submitted to the Quality Assurance Committee for the duration of the audits noted above. Should the committee feel that systemic compliance is not being achieved then audits will continue, with possible additional corrective action, until compliance has been achieved.	

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	No nurses notes or neurological checks were recorded from 9:15 p.m., on 7/28/11 until the next day, 7/29/11 at 7:30 a.m. The entry at 7:30 a.m., indicated the blood pressure was 126/64, pulse 78, respirations 16 and temperature 97.2. The note also indicated he was alert and oriented and his pupils were equal and reactive to light. The facility policy for head injuries, dated 1/27/2004, and provided by RN #400, on 1/23/12 at 11:00 a.m., indicated a Neuro Assessment Checklist flow sheet was to be completed and neurological assessments were to be done every 15 minutes for the first hour, then every hour for 3 hours, followed by every 2 hours for two times, then every 4 hours for four times, followed by every 8 hours for three times and finally every 12 hours two times. During an interview with RN #400, on 1/23/12 at 11:30 a.m., she indicated the neurological checks had not been done as the policy indicated.			

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R0148	(e) The facility shall maintain buildings, grounds, and equipment in a clean condition, in good repair, and free of hazards that may adversely affect the health and welfare of the residents or the public as follows: (1) Each facility shall establish and implement a written program for maintenance to ensure the continued upkeep of the facility. (2) The electrical system, including appliances, cords, switches, alternate power sources, fire alarm and detection systems, shall be maintained to guarantee safe functioning and compliance with state electrical codes. (3) All plumbing shall function properly and comply with state plumbing codes. (4) At least yearly, heating and ventilating systems shall be inspected.			
	Based on observation, interviews and record review, the facility failed to ensure electrical outlets within three feet of water supplies in resident bathrooms were protected with ground fault current interrupters (gfci) This affected 20 of 45 residents living in the assisted living area of the facility. Findings include: During the orientation tour, on 1/23/12 at 9:55 a.m., with RN #400, the laundry room on the south hall was observed to have an electrical outlet within 3 feet of the sink. No gfci was present in the outlet. This area was identified by RN #400 as being used by residents to do personal laundry.	R0148	**What measures were taken for residents directly affected?** No residents were directly affected by this noncompliant practice. **What measures were put in place to identify other residents at risk?** All residents are at risk to be affected by this noncompliant practice. All required outlets have been replaced with GFCI outlets. **What systemic change was put in place to ensure the deficient practice does not recur?** All facility electrical outlets meet compliance with life safety code. Any future outlets installed in similar areas will be of the ground fault interrupter (GFCI) type. All pertinent staff has been in-serviced on this new practice. **How will the corrective action**	02/26/2012

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	Maintenance staff member #402 was interviewed, on 1/23/12 at 2:30 p.m., about the number of unprotected outlets in the facility. He indicated the facility had been cited during the annual survey in January 2011, for no gfci outlet over the beauty shop sink and the facility had replaced the beauty shop outlet with a gfci outlet. He indicated the facility had been aware of other outlets which were not ground fault protected either through the main electrical panel or through individual gfci outlets. He provided a facility layout, with room numbers which identified which had been replaced and which had not. All of the rooms, except one (433) on the south hall had been changed. The north hall had three outlets replaced with gfci protected outlets, and the remainder of the rooms had not been replaced. A total of 19 residents were in rooms which had not had the gfci outlets installed. The remainder of the rooms on the north hall were empty at present. The rooms which had residents living in them and had not been gfci protected were: 203, 208, 212, 214, 215, 217, 224, 225, 227, 230, 232, 237, 238, 244, 250, 252, 253, 254 and 255.		**be monitored?** The Director of Maintenance and/or designee will monitor the installation of any new electrical outlets to ensure the GFCI type is installed.	

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